AMERICAN COLLEGE OF RHEUMATOLOGY
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Specialists in Arthritis Care & Research

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January 26, 2016

The Honorable Orrin Hatch
Chairman
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Johnny Isakson
United States Senator
131 Russell Senate Office Building
Washington, DC 20510

The Honorable Mark R. Warner
United States Senator
475 Russell Senate Office Building
Washington, DC 20510

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson, and Senator Warner:

The American College of Rheumatology, representing over 9,500 rheumatologists and health professionals, shares the Chronic Care Working Group's goal of developing policies that will improve outcomes for Medicare patients with chronic conditions. We appreciate this opportunity to provide additional suggestions that will incentivize the appropriate level of care for patients living with chronic diseases and facilitate the delivery of high quality care producing superior outcomes.

Rheumatologists treat patients with serious chronic conditions that can be difficult to diagnose and treat, including rheumatoid arthritis, osteoarthritis and other debilitating and potentially-disabling rheumatic diseases. **Rheumatic diseases are the number one cause of disability in the United States and lead to higher costs than cancer care.** Inflammatory rheumatic diseases cause more disability in America than heart disease, cancer or diabetes. Over 11 million American adults suffer from inflammatory rheumatic diseases. Rheumatic diseases of this nature include the group of autoimmune and inflammatory diseases that cause the immune system to unleash an attack on a person's joints, muscles, bones and other organs.

Rheumatologists primarily provide face-to-face, non-procedural care in which they evaluate, manage, and treat patients' complex chronic and acute conditions. **Early access to a rheumatologist who can prescribe timely interventions have been shown in numerous well-designed studies to improve patient outcomes and prevent disability and costly procedures.** Although many diseases are managed by primary care internists and family practitioners, some diseases require expertise beyond that of primary care providers and are best managed by specialists trained to diagnose and treat them. Rheumatologists provide ongoing care for Medicare beneficiaries with complex chronic and acute conditions that require expertise beyond that of primary care providers, and are the principal care providers for many of our patients. Lack of access to rheumatologists can lead to significant increased cost because of greater health care spending on extended hospital stays and tests, and the indirect costs of increased unemployment and disability payments.

Executive Summary

The American College of Rheumatology supports many of the policies being considered by the Working Group, including giving Medicare Advantage plans the flexibility to establish a benefit

structure that varies based on chronic conditions of individual enrollees. We firmly believe that greater patient access to care that would slow or prevent progression of chronic disease should be a focus of the MA plans. For that reason, we endorse both: a) allowing MA plans to undertake reduction in cost sharing for items/services that treat the chronic condition or prevent the progression of the chronic disease; and b) adjustments to provider networks that allow for a greater inclusion of providers and non-clinical professionals to treat the chronic condition or prevent the progression of the chronic disease, which would promote more prompt patient access to care. We also support other policy options including requiring CMMI to issue required notice and comment rulemaking for all models that affect a significant amount of Medicare spending, providers or beneficiaries, or requiring CMMI to issue notice and comment rulemaking for all mandatory models and at least a 30 day public comment period for all other innovation models.

We wish to provide more extensive comments on our support for two policy options summarized in the Working Group's document, in particular:

1. **Improving Care Management Services for Individuals with Multiple Chronic Conditions:** Establishing a new high-severity chronic care management code.

2. **Ensuring Accurate Payment for Chronically Ill Individuals:** Making changes to the CMS Hierarchical Conditions Category (HCC) Risk Adjustment Model.

1. Improving Care Management Services for Individuals with Multiple Chronic Conditions

We applaud and support the working group's consideration of a new high-severity chronic care management code that clinicians could bill under the Physician Fee Schedule. A new code would reimburse clinicians for coordinating care outside of a face-to-face encounter for Medicare's most complex beneficiaries living with multiple chronic conditions. Beneficiaries with multiple chronic conditions have complex, time intensive, and labor intensive care management needs that extend beyond the time available during an in-person visit with a clinician. The current Chronic Care Management (CCM) code created by CMS allows a provider to bill one patient, per month for a 20 minute time allotment spanning a 30 day timeframe.

We agree that the structure of the current CCM code is insufficient to capture the time needed for a clinician to manage a complex patient's care. As the intent of these codes is to cover a portion of the labor-intensive cost of managing multiple chronic conditions, we agree that it would be appropriate for a new high-severity code payment to be higher to compensate providers who require more than the typical allotted time per month. As structured, the administrative requirements of the CCM code are not commensurate with the reimbursement of approximately $42.

Most importantly, we ask that the Working Group pay special attention to the fact that rheumatologists and other cognitive specialists are generally not able to utilize the new CCM code that was created by CMS. Rheumatologists and other cognitive specialists by virtue of the nature of their specialty practice should be a prominent user of the CCM payment. However, several requirements for the CCM payment are far too onerous for most rheumatologists, reducing their participation in this program. We would appreciate the opportunity to provide further input and review to the Working Group as requirements for the code are considered, to ensure that cognitive specialists, who should be a major focus for chronic care management efforts, can actually utilize the new code.

There are several components of the current CCM code that make utilizing the code unworkable for many rheumatologists and similar subspecialists. The requirement for 24-hour coverage alone makes the payment not feasible for most rheumatologists. The use of time metrics for code documentation is also inefficient and impractical. Our experience with care management indicates that typically multiple short phone calls involving multiple providers and the patient are made each month. A less onerous method of logging and timekeeping than currently employed would be a great improvement.

We note that the care management needs of beneficiaries can vary considerably from month to month. There may be some months during which a 5-minute phone call is all that is necessary to assure a patient is stable, but there are also months during which an hour or more of telephone contact will be required to resolve diagnostic and treatment issues and ensure appropriate management when the manifestations of these chronic diseases and their complications are evolving between regularly scheduled appointments. The requirement of 20 minutes per beneficiary per month imposes an unrealistic expectation that will foster unnecessary phone calls and documentation and divert attention and resources away from the care of those patients who require more intensive intervention.

Regarding the types of providers who should be eligible to bill the new high severity chronic care code, we strongly advise that the working group pay close attention to structuring the requirements in order to allow cognitive specialists such as rheumatologists and other appropriate subspecialists to qualify for utilization of the codes. We ask CMS to remember that many specialists engage in the chronic care management described by these codes and ask that CMS undertake revisions to these service codes in order to promote their use by these specialists primarily engaged in this variety of continuous cognitive work.

We support the concept that patients eligible for this high-severity chronic care management services should include those patients with a chronic condition in conjunction with an impaired functional status or other complicating condition.

2. Ensuring Accurate Payment for Chronically Ill Individuals

Currently payments made to Medicare Advantage (MA) plans are risk adjusted using the CMS Hierarchical Conditions Category (HCC) Risk Adjustment Model. We applaud and support the Working Group's consideration of changes to the risk adjustment model. We recommend that in addition to the possible changes outlined in the policy options document, the Working Group should consider adding use of biologic treatments as an indicator of patients with severe disease and higher risks and associated costs.

Patients who receive biologic treatments have severe and complex medical problems, and use of a biologic would be an appropriate addition to the risk adjustment model. Biologics approved for the treatment of autoimmune conditions are specifically designed to modify immune responses, and carry increased costs and risk. By virtue of their interactions with cells and chemicals in the body, these drugs carry a high risk for serious reactions as reflected in their FDA labeling. Each biologic comes with a black box warning. As a result of their complex molecular structure and mechanism of action, the administration of biologics requires specialized handling and monitoring. Health care professionals who administer biologics must have advanced training and expertise above and beyond that which is required for the administration of small molecule pharmaceutical agents.

Additional Recommendation: Create New Evaluation and Management Codes to More Accurately Describe Chronic Care Services Provided by Cognitive Physicians

Over the last twenty-five years, the expectations for optimal care of chronic illness have caused a paradigm shift for Medicare beneficiaries. New and complicated diagnostic and treatment algorithms have emerged with the increased understanding of complex presenting symptoms and disease states, as well as the early identification and prevention of disease complications. There has been an explosion of treatment options with increasingly complicated interactions among specialists. Rheumatologists and similar specialists regularly treat patients with multiple coexisting chronic conditions, often utilizing multiple medications for effective care. This work involves brief, focused physical exams, the determination of patient goals, medication reconciliation, the assessment and integration of hundreds of data points, the effective coordination of multiple consultants, collaboration with team members, continuous development and modification of care plans, patient or caregiver education, and constant communication.

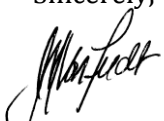
A byproduct of this transformation in care is that the CPT codes for outpatient E&M services no longer describe the work performed by physicians and their clinical staff. Specifically, the existing office codes (CPT 99201-5 and 9921-5) no longer accurately or adequately reflect the work currently provided to and required by Medicare beneficiaries. **It is critical that a new set of codes is created to describe the work involved in E&M services provided by cognitive physicians.**

The existing E&M codes are flawed and do not reflect the following:
• The increase in the complexity-density of E&M work resulting from the expansion of inputs and outputs from medical decision-making.
• Physicians' focus on caring for lifelong, chronic illnesses, preventing complications from these illnesses and/or exploring complicated diagnostic and therapeutic pathways.
• The post-visit work – including care coordination, patient counseling, and other necessary follow up – extends well beyond what is included in these codes.

In summary, cognitive physicians such as rheumatologists routinely address more than one chronic condition in a single patient visit and coordinate and manage care for patients as a member of a multidisciplinary team outside of the face-to-face patient visit, but this work is not adequately described by the current evaluation and management codes. **We recommend that creation of new E&M codes be included in the Senate Finance Committee's considerations for bolstering chronic disease management.**

The American College of Rheumatology appreciates your leadership and your commitment to improving outcomes for Medicare patients with chronic conditions. We are available to assist you and provide information and data as you continue to refine policy options to reach your important goals. If you have questions or if we can provide further information, please contact Adam Cooper, senior director of government affairs, at (404) 633-3777 or acooper@rheumatology.org

Sincerely,



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President, American College of Rheumatology